



General Assembly

January Session, 2003

Raised Bill No. 917

LCO No. 3193

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING PREFERRED PROVIDER NETWORKS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-479aa of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective October 1, 2003*):

3 (a) As used in this section, sections 2 to 4, inclusive, of this act, and
4 subsection (b) of section 20-138b:

5 (1) "Covered benefits" means health care services to which an
6 enrollee is entitled under the terms of a managed care plan;

7 (2) "Enrollee" means an individual who is eligible to receive health
8 care services through a preferred provider network;

9 [(1)] (3) "Health care services" means health care related services or
10 products rendered or sold by a provider within the scope of the
11 provider's license or legal authorization, and includes hospital,
12 medical, surgical, dental, vision and pharmaceutical services or
13 products;

14 (4) "Managed care organization" means a managed care

15 organization, as defined in section 38a-478;

16 (5) "Managed care plan" means a managed care plan, as defined in
17 section 38a-478;

18 [(2)] (6) "Person" means an individual, agency, political subdivision,
19 partnership, corporation, limited liability company, association or any
20 other entity;

21 [(3)] (7) "Preferred provider network" or "network" means [an
22 arrangement in which agreements relating to the health care services
23 to be rendered by providers, including the amounts to be paid to the
24 providers for such services, are entered into between such providers
25 and a person who establishes, operates, maintains or underwrites the
26 arrangement, in whole or in part, and includes any provider-
27 sponsored preferred provider network or independent practice
28 association that offers network services, but] a person, which is not a
29 managed care organization, but which accepts financial liability for the
30 delivery of health care services and establishes, operates or maintains
31 an arrangement or contract with providers relating to (A) the health
32 care services rendered by the providers and (B) the amounts to be paid
33 to the providers for such services. "Preferred provider network" or
34 "network" does not include a workers' compensation preferred
35 provider organization established pursuant to section 31-279-10 of the
36 regulations of Connecticut state agencies; [or an arrangement relating
37 only to health care services offered by providers to individuals covered
38 under self-insured Employee Welfare Benefit Plans established
39 pursuant to the federal Employee Retirement Income Security Act of
40 1974, as from time to time amended;]

41 [(4)] (8) "Provider" means an individual or entity duly licensed or
42 legally authorized to provide health care services; and

43 [(5)] (9) "Commissioner" means the Insurance Commissioner.

44 [(b) All preferred provider networks shall file with the

45 commissioner prior to the start of enrollment and shall annually
46 update such filing by July first of each year thereafter.]

47 (b) On and after May 1, 2004, no preferred provider network may
48 conduct business in this state unless it is licensed by the commissioner.
49 Any person seeking to obtain or renew a license shall submit an
50 application to the commissioner, on such form as the commissioner
51 may prescribe, and shall include the filing described in this subsection,
52 except that a person seeking to renew a license may submit only the
53 information necessary to update its previous filing. Applications shall
54 be submitted by March first of each year in order to qualify for the
55 May first license issue or renewal date. The filing required by such
56 preferred provider network shall include the following information:
57 (1) The identity of the preferred provider network and any company or
58 organization controlling the operation of the preferred provider
59 network, including the name, business address, contact person, a
60 description of [such] the controlling company or organization and,
61 where applicable, the following: (A) A certificate from the Secretary of
62 the State regarding the preferred provider network's and the
63 controlling company's or organization's good standing to do business
64 in the state; (B) a copy of the preferred provider network's and the
65 controlling company's or organization's [balance sheet at] financial
66 statement completed in accordance with section 38a-54, as applicable,
67 for the end of its most recently concluded fiscal year, along with the
68 name and address of any public accounting firm or internal accountant
69 which prepared or assisted in the preparation of such [balance sheet]
70 financial statement; (C) a list of the names, official positions and
71 occupations of members of the preferred provider network's and the
72 controlling company's or organization's board of directors or other
73 policy-making body and of those executive officers who are
74 responsible for the preferred provider network and controlling
75 company's or organization's activities with respect to the [medical
76 care] health care services network; (D) a list of the preferred provider
77 network's and the controlling company's or organization's principal

78 owners; (E) in the case of an out-of-state preferred provider network,
 79 controlling company or organization, a certificate that such preferred
 80 provider network, company or organization is in good standing in its
 81 state of organization; (F) in the case of a Connecticut or out-of-state
 82 preferred provider network, controlling company or organization, a
 83 report of the details of any suspension, sanction or other disciplinary
 84 action relating to such network, or controlling company or
 85 organization in this state or in any other state; and (G) the identity,
 86 address and current relationship of any related or predecessor
 87 controlling company or organization. For purposes of this
 88 subparagraph, "related" means that a substantial number of the board
 89 or policy-making body members, executive officers or principal
 90 owners of both companies are the same; (2) a general description of the
 91 preferred provider network and participation in the preferred provider
 92 network, including: (A) The geographical service area of and the
 93 names of the hospitals included in the preferred provider network;
 94 [and] (B) the primary care physicians, the specialty physicians, any
 95 other contracting [health care] providers and the number and
 96 percentage of each group's capacity to accept new patients; (C) a list of
 97 all entities on whose behalf the preferred provider network has
 98 contracts or agreements to provide health care services; (D) a table
 99 listing all major categories of health care services provided by the
 100 preferred provider network; (E) an approximate number of total
 101 enrollees served in all of the preferred provider network's contracts or
 102 agreements; (F) a list of subcontractors of the preferred provider
 103 network, not including individual participating providers, that assume
 104 financial risk from the preferred provider network and to what extent
 105 each subcontractor assumes financial risk; (G) a contingency plan
 106 describing how contracted health care services will be provided in the
 107 event of insolvency; and (H) any other information requested by the
 108 commissioner; and (3) the name and address of the person to whom
 109 applications may be made for participation.

110 (c) Any person developing a preferred provider network, or
 111 expanding a preferred provider network into a new county, pursuant

112 to this section and subsection (b) of section 20-138b, shall publish a
113 notice, in at least one newspaper having a substantial circulation in the
114 service area in which the preferred provider network operates or will
115 operate, indicating such planned development or expansion. Such
116 notice shall include the medical specialties included in the preferred
117 provider network, the name and address of the person to whom
118 applications may be made for participation and a time frame for
119 making application. The preferred provider network shall provide the
120 applicant with written acknowledgment of receipt of the application.
121 Each complete application shall be considered by the preferred
122 provider network in a timely manner.

123 (d) (1) Each preferred provider network shall file with the
124 commissioner and make available upon request from a provider [,] the
125 general criteria for its selection or termination of providers. Disclosure
126 shall not be required of criteria deemed by the preferred provider
127 network to be of a proprietary or competitive nature that would hurt
128 the preferred provider network's ability to compete or to manage
129 health care services. For purposes of this section, [disclosure of] criteria
130 is of a proprietary or [anticompetitive] competitive nature if it has the
131 tendency to cause [health care] providers to alter their practice pattern
132 in a manner that would circumvent efforts to contain health care costs
133 and criteria is of a proprietary nature if revealing the criteria would
134 cause the preferred provider network's competitors to obtain valuable
135 business information.

136 (2) If a preferred provider network uses criteria that have not been
137 filed pursuant to subdivision (1) of this subsection to judge the quality
138 and cost-effectiveness of a provider's practice under any specific
139 program within the preferred provider network, the preferred
140 provider network may not reject or terminate the provider
141 participating in that program based upon such criteria until the
142 provider has been informed of the criteria that the provider's practice
143 fails to meet.

144 (e) A preferred provider network [which has a limited network and
145 which does not provide any reimbursement when an enrollee obtains
146 service outside that limited network shall inform each applicant of that
147 fact prior to enrolling the applicant for coverage] shall permit the
148 Insurance Commissioner to inspect its books and records.

149 (f) Each preferred provider network shall permit the commissioner
150 to examine, under oath, any officer or agent of the preferred provider
151 network or controlling company or organization with respect to the
152 use of the funds of the network, company or organization, and
153 compliance with (1) the provisions of this part and sections 2 to 4,
154 inclusive, of this act, and (2) the terms and conditions of its contracts to
155 provide health care services.

156 (g) Each preferred provider network shall file with the
157 commissioner a notice of any material modification of any matter or
158 document furnished pursuant to this part, and sections 2 to 4,
159 inclusive, of this act, and shall include such supporting documents as
160 are necessary to explain the modification.

161 (h) Each preferred provider network shall maintain a minimum net
162 worth of either (A) the greater of (i) two hundred fifty thousand
163 dollars, or (ii) an amount equal to eight per cent of its annual
164 expenditures as reported on its most recent financial statement
165 completed and filed with the commissioner in accordance with section
166 38a-54, or (B) another amount determined by the commissioner.

167 (i) Each preferred provider network shall maintain or arrange for a
168 letter of credit, bond, surety, reinsurance, or other financial security
169 acceptable to the commissioner in an amount equal to any outstanding
170 amounts owed by the preferred provider network to its participating
171 providers for the exclusive use of paying any outstanding amounts
172 owed participating providers in the event of insolvency. Such amount
173 may be credited against the network's minimum net worth
174 requirements set forth in subsection (h) of this section.

175 (j) Each preferred provider network shall pay the applicable license
176 or renewal fee specified in section 38a-11, as amended by this act. The
177 commissioner shall use the amount of such fees solely for the purpose
178 of regulating preferred provider networks.

179 (k) In no event, including, but not limited to, nonpayment by the
180 managed care organization, insolvency of the managed care
181 organization, or breach of contract between the managed care
182 organization and the preferred provider network, shall a preferred
183 provider network bill, charge, collect a deposit from, seek
184 compensation, remuneration or reimbursement from, or have any
185 recourse against an enrollee or enrollee's designee, other than the
186 managed care organization, for covered benefits provided.

187 (l) Each contract or agreement between a preferred provider
188 network and a participating provider shall contain a provision that if
189 the preferred provider network fails to pay for health care services as
190 set forth in the contract, the enrollee shall not be liable to the
191 participating provider for any sums owed by the managed care
192 organization or preferred provider network.

193 Sec. 2. (NEW) (*Effective May 1, 2005*) (a) On and after May 1, 2005, no
194 managed care organization may enter into, renew, continue or
195 maintain a contractual relationship with a preferred provider network
196 that is not licensed in accordance with section 38a-479aa of the general
197 statutes, as amended by this act.

198 (b) Each managed care organization that contracts with a preferred
199 provider network shall maintain or require the preferred provider
200 network to maintain a letter of credit, bond, surety, reinsurance, or
201 other financial security acceptable to the Insurance Commissioner in
202 an amount equal to any outstanding amounts owed by the preferred
203 provider network to its participating providers for the exclusive use of
204 paying any outstanding amounts owed participating providers in the
205 event of insolvency.

206 (c) Each managed care organization that contracts with a preferred
207 provider network shall provide at the time the contract is entered into
208 and annually thereafter:

209 (1) Information, as determined by the managed care organization,
210 regarding the amount and method of remuneration to be paid to the
211 preferred provider network;

212 (2) Information, as determined by the managed care organization, to
213 assist the preferred provider network in being informed regarding any
214 financial risk assumed under the contract or agreement, including, but
215 not limited to, enrollment data, primary care provider to covered
216 person ratios, provider to covered person ratios by specialty, a table of
217 the services that the preferred provider network is responsible for,
218 expected or projected utilization rates, and all factors used to adjust
219 payments or risk-sharing targets;

220 (3) The National Associations of Insurance Commissioners annual
221 statement for the managed care organization; and

222 (4) Any other information the commissioner may require.

223 (d) Each managed care organization shall ensure that any contract it
224 has with a preferred provider network includes:

225 (1) A provision that requires the preferred provider network to
226 provide to the managed care organization at the time a contract is
227 entered into, annually, and upon request of the managed care
228 organization, (A) the financial statement completed in accordance with
229 section 38a-54 of the general statutes, as applicable, and section 38a-
230 479aa of the general statutes, as amended by this act; (B)
231 documentation that satisfies the managed care organization that the
232 preferred provider network has sufficient ability to accept financial
233 risk; and (C) documentation that satisfies the managed care
234 organization that a preferred provider network has appropriate
235 management expertise and infrastructure;

236 (2) A provision that requires the preferred provider network to
237 provide to the managed care organization a quarterly status report that
238 includes (A) information updating the financial statement completed
239 in accordance with section 38a-54 of the general statutes, as applicable,
240 and section 38a-479aa of the general statutes, as amended by this act;
241 (B) a report showing amounts paid to those providers who provide
242 health care services on behalf of the managed care organization; (C) an
243 estimate of payments due providers but not yet reported by providers;
244 and (D) amounts owed to providers for that quarter;

245 (3) A provision that requires the preferred provider network to
246 provide notice to the managed care organization not later than thirty
247 days after (A) any change involving the ownership structure of the
248 preferred provider network; (B) financial or operational concerns
249 regarding the financial viability of the preferred provider network; or
250 (C) the preferred provider network's loss of a license in this or any
251 other state;

252 (4) A provision that if the managed care organization fails to pay for
253 health care services as set forth in the contract, the enrollee will not be
254 liable to the provider or preferred provider network for any sums
255 owed by the managed care organization or preferred provider
256 network;

257 (5) A provision that the preferred provider network shall include in
258 all contracts between the preferred provider network and participating
259 providers a provision that if the preferred provider network fails to
260 pay for health care services as set forth in the contract, for any reason,
261 the enrollee will not be liable to the participating provider or preferred
262 provider network for any sums owed by the managed care
263 organization or preferred provider network;

264 (6) A provision requiring the preferred provider network to provide
265 information to the managed care organization, satisfactory to the
266 managed care organization, regarding the preferred provider
267 network's reserves for financial risk;

268 (7) A provision that the preferred provider network or managed
269 care organization shall post and maintain a letter of credit, bond,
270 surety, reinsurance, or other financial security acceptable to the
271 commissioner in an amount equal to any outstanding amounts owed
272 by the preferred provider network to its participating providers for the
273 exclusive use of paying any outstanding amounts owed participating
274 providers in the event of insolvency;

275 (8) A provision under which the managed care organization is
276 permitted, at the discretion of the managed care organization, to pay
277 participating providers directly and in lieu of the preferred provider
278 network, in the event of insolvency or mismanagement by the
279 preferred provider network;

280 (9) A provision transferring and assigning contracts between the
281 preferred provider network and participating providers to the
282 managed care organization for the provision of future services by
283 participating providers to enrollees, at the discretion of the managed
284 care organization, in the event the preferred provider network
285 becomes insolvent; and

286 (10) A provision that each contract or agreement between the
287 preferred provider network and participating providers shall include a
288 provision transferring and assigning contracts between the preferred
289 provider network and participating providers to the managed care
290 organization for the provision of future health care services by
291 participating providers to enrollees, at the discretion of the managed
292 care organization, in the event the preferred provider network
293 becomes insolvent.

294 (e) Each managed care organization that contracts with a preferred
295 provider network shall have adequate procedures in place to notify the
296 commissioner that a preferred provider network has experienced an
297 event that may threaten the preferred provider network's ability to
298 materially perform under its contract with the managed care
299 organization. The managed care organization shall provide such notice

300 to the commissioner not later than five days after it discovers that the
301 preferred provider network has experienced such an event.

302 (f) Each managed care organization that contracts with a preferred
303 provider network shall monitor and maintain systems and controls for
304 monitoring the financial health of the preferred provider networks
305 with which it contracts.

306 (g) Each managed care organization that contracts with a preferred
307 provider network shall provide to the commissioner, and update on an
308 annual basis, a contingency plan, satisfactory to the commissioner,
309 describing how health care services will be provided to enrollees if the
310 preferred provider network becomes insolvent or is mismanaged. The
311 contingency plan shall include a description of what contractual and
312 financial steps have been taken to ensure continuity of care to enrollees
313 if the preferred provider network becomes insolvent or is
314 mismanaged.

315 (h) Notwithstanding any agreement to the contrary, each managed
316 care organization shall retain full responsibility for the provision of
317 health care services pursuant to any applicable managed care plan or
318 any applicable state or federal law.

319 (i) Notwithstanding any agreement to the contrary, each managed
320 care organization shall be able to demonstrate to the satisfaction of the
321 commissioner that the managed care organization can fulfill its
322 nontransferable obligation to provide health care services to enrollees
323 in any event, including, but not limited to, the failure, for any reason,
324 of a preferred provider network.

325 (j) Nothing in section 38a-479aa of the general statutes, as amended
326 by this act, or sections 2 to 4, inclusive, of this act, shall be construed to
327 require a preferred provider network to share proprietary information
328 with a managed care organization concerning contracts or
329 arrangements with providers or other preferred provider networks or
330 managed care organizations.

331 Sec. 3. (NEW) (*Effective October 1, 2003*) (a) If the Insurance
 332 Commissioner determines that a preferred provider network or
 333 managed care organization, or both, have not complied with any
 334 provision in section 38a-479aa of the general statutes, as amended by
 335 this act, or sections 2 to 4, inclusive, of this act, the commissioner may
 336 (1) order the preferred provider network or managed care
 337 organization, or both, to cease and desist all operations in violation of
 338 said sections; (2) terminate or suspend the preferred provider
 339 network's license; (3) institute a corrective action against the preferred
 340 provider network or managed care organization, or both; (4) order the
 341 payment of a civil penalty by the preferred provider network or
 342 managed care organization, or both, of not more than one thousand
 343 dollars for each and every act or violation; (5) order the payment of
 344 such reasonable expenses as may be necessary to compensate the
 345 commissioner in conjunction with any proceedings held to investigate
 346 or enforce violations of section 38a-479aa of the general statutes, as
 347 amended by this act, and sections 2 to 4, inclusive, of this act; and (6)
 348 use any of the commissioner's other enforcement powers to obtain
 349 compliance with section 38a-479aa of the general statutes, as amended
 350 by this act, and sections 2 to 4, inclusive, of this act. The commissioner
 351 may hold a hearing concerning any matter governed by section 38a-
 352 479aa of the general statutes, as amended by this act, or sections 2 to 4,
 353 inclusive, of this act, in accordance with section 38a-16 of the general
 354 statutes. Subject to the same confidentiality and liability protections set
 355 forth in subsections (c) and (k) of section 38a-14 of the general statutes,
 356 the commissioner may engage the services of attorneys, appraisers,
 357 independent actuaries, independent certified public accountants or
 358 other professionals and specialists to assist the commissioner in
 359 conducting an investigation under this section, the cost of which shall
 360 be borne by the managed care organization or preferred provider
 361 network, or both, that are the subject of the investigation.

362 (b) If a preferred provider network fails to comply with any
 363 provision of section 38a-479aa of the general statutes, as amended by
 364 this act, or sections 2 to 4, inclusive, of this act, the commissioner may

365 assign or require the preferred provider network to assign its rights
366 and obligations under any contract with participating providers in
367 order to ensure that covered benefits are provided.

368 (c) The commissioner shall receive and investigate any grievance
369 filed against a preferred provider network or managed care
370 organization, or both, by an enrollee or an enrollee's designee
371 concerning matters governed by section 38a-479aa of the general
372 statutes, as amended by this act, or sections 2 to 4, inclusive, of this act.
373 The commissioner shall code, track and review such grievances. The
374 preferred provider network or managed care organization, or both,
375 shall provide the commissioner with all information necessary for the
376 commissioner to investigate such grievances. The information
377 collected by the commissioner pursuant to this section shall be
378 maintained as confidential and shall not be disclosed to any person
379 except to the extent necessary to carry out the purposes of section 38a-
380 479aa of the general statutes, as amended by this act, and sections 2
381 and 3 of this act, and as allowed under title 38a of the general statutes.

382 Sec. 4. (NEW) (*Effective October 1, 2003*) The Insurance
383 Commissioner may adopt regulations, in accordance with chapter 54
384 of the general statutes, to implement the provisions of section 38a-
385 479aa of the general statutes, as amended by this act, and sections 2
386 and 3 of this act.

387 Sec. 5. Subsection (a) of section 38a-11 of the general statutes is
388 repealed and the following is substituted in lieu thereof (*Effective*
389 *October 1, 2003*):

390 (a) The commissioner shall demand and receive the following fees:
391 (1) For the annual fee for each license issued to a domestic insurance
392 company, one hundred dollars; (2) for receiving and filing annual
393 reports of domestic insurance companies, twenty-five dollars; (3) for
394 filing all documents prerequisite to the issuance of a license to an
395 insurance company, one hundred seventy-five dollars, except that the
396 fee for such filings by any health care center, as defined in section 38a-

397 175, shall be one thousand one hundred dollars; (4) for filing any
398 additional paper required by law, fifteen dollars; (5) for each certificate
399 of valuation, organization, reciprocity or compliance, twenty dollars;
400 (6) for each certified copy of a license to a company, twenty dollars; (7)
401 for each certified copy of a report or certificate of condition of a
402 company to be filed in any other state, twenty dollars; (8) for
403 amending a certificate of authority, one hundred dollars; (9) for each
404 license issued to a rating organization, one hundred dollars. In
405 addition, insurance companies shall pay any fees imposed under
406 section 12-211; (10) a filing fee of twenty-five dollars for each initial
407 application for a license made pursuant to section 38a-769; (11) with
408 respect to insurance agents appointments: (A) A filing fee of twenty-
409 five dollars for each request for any agent appointment; (B) a fee of
410 forty dollars for each appointment issued to an agent of a domestic
411 insurance company or for each appointment continued; and (C) a fee
412 of twenty dollars for each appointment issued to an agent of any other
413 insurance company or for each appointment continued, except that no
414 fee shall be payable for an appointment issued to an agent of an
415 insurance company domiciled in a state or foreign country which does
416 not require any fee for an appointment issued to an agent of a
417 Connecticut insurance company; (12) with respect to insurance
418 producers: (A) An examination fee of seven dollars for each
419 examination taken, except when a testing service is used, the testing
420 service shall pay a fee of seven dollars to the commissioner for each
421 examination taken by an applicant; (B) a fee of forty dollars for each
422 license issued; and (C) a fee of forty dollars for each license renewed;
423 (13) with respect to public adjusters: (A) An examination fee of seven
424 dollars for each examination taken, except when a testing service is
425 used, the testing service shall pay a fee of seven dollars to the
426 commissioner for each examination taken by an applicant; and (B) a fee
427 of one hundred twenty-five dollars for each license issued or renewed;
428 (14) with respect to casualty adjusters: (A) An examination fee of ten
429 dollars for each examination taken, except when a testing service is
430 used, the testing service shall pay a fee of ten dollars to the

431 commissioner for each examination taken by an applicant; (B) a fee of
432 forty dollars for each license issued or renewed; and (C) the expense of
433 any examination administered outside the state shall be the
434 responsibility of the entity making the request and such entity shall
435 pay to the commissioner one hundred dollars for such examination
436 and the actual traveling expenses of the examination administrator to
437 administer such examination; (15) with respect to motor vehicle
438 physical damage appraisers: (A) An examination fee of forty dollars
439 for each examination taken, except when a testing service is used, the
440 testing service shall pay a fee of forty dollars to the commissioner for
441 each examination taken by an applicant; (B) a fee of forty dollars for
442 each license issued or renewed; and (C) the expense of any
443 examination administered outside the state shall be the responsibility
444 of the entity making the request and such entity shall pay to the
445 commissioner one hundred dollars for such examination and the
446 actual traveling expenses of the examination administrator to
447 administer such examination; (16) with respect to certified insurance
448 consultants: (A) An examination fee of thirteen dollars for each
449 examination taken, except when a testing service is used, the testing
450 service shall pay a fee of thirteen dollars to the commissioner for each
451 examination taken by an applicant; (B) a fee of two hundred dollars for
452 each license issued; and (C) a fee of one hundred twenty-five dollars
453 for each license renewed; (17) with respect to surplus lines brokers: (A)
454 An examination fee of ten dollars for each examination taken, except
455 when a testing service is used, the testing service shall pay a fee of ten
456 dollars to the commissioner for each examination taken by an
457 applicant; and (B) a fee of five hundred dollars for each license issued
458 or renewed; (18) with respect to fraternal agents, a fee of forty dollars
459 for each license issued or renewed; (19) a fee of thirteen dollars for
460 each license certificate requested, whether or not a license has been
461 issued; (20) with respect to domestic and foreign benefit societies shall
462 pay: (A) For service of process, twenty-five dollars for each person or
463 insurer to be served; (B) for filing a certified copy of its charter or
464 articles of association, five dollars; (C) for filing the annual report, ten

465 dollars; and (D) for filing any additional paper required by law, three
 466 dollars; (21) with respect to foreign benefit societies: (A) For each
 467 certificate of organization or compliance, four dollars; (B) for each
 468 certified copy of permit, two dollars; and (C) for each copy of a report
 469 or certificate of condition of a society to be filed in any other state, four
 470 dollars; (22) with respect to reinsurance intermediaries: A fee of five
 471 hundred dollars for each license issued or renewed; (23) with respect
 472 to viatical settlement providers: (A) A filing fee of thirteen dollars for
 473 each initial application for a license made pursuant to section 38a-465a;
 474 and (B) a fee of twenty dollars for each license issued or renewed; (24)
 475 with respect to viatical settlement brokers: (A) A filing fee of thirteen
 476 dollars for each initial application for a license made pursuant to
 477 section 38a-465a; and (B) a fee of twenty dollars for each license issued
 478 or renewed; (25) with respect to preferred provider networks, a fee of
 479 two thousand five hundred dollars for each license issued or renewed;
 480 (26) with respect to rental companies, as defined in section 38a-799, a
 481 fee of forty dollars for each permit issued or renewed; and [(26)] (27)
 482 with respect to each duplicate license issued a fee of twenty-five
 483 dollars for each license issued.

This act shall take effect as follows:	
Section 1	<i>October 1, 2003</i>
Sec. 2	<i>May 1, 2005</i>
Sec. 3	<i>October 1, 2003</i>
Sec. 4	<i>October 1, 2003</i>
Sec. 5	<i>October 1, 2003</i>

Statement of Purpose:

To revise provisions concerning the licensure, contracts, and solvency of preferred provider networks.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]